Department of Human Resources 311 West Saratoga Street Baltimore MD 21201	**Family Investment Administration** **ACTION TRANSMITTAL**
Control Number: 12-06	**Effective Date: Upon Receipt**
	Issuance Date: September 9, 2011

TO: DIRECTORS, LOCAL DEPARTMENTS OF SOCIAL SERVICES
DEPUTY/ASSISTANT DIRECTORS FOR FAMILY INVESTMENT
FAMILY INVESTMENT SUPERVISORS

FROM: ROSEMARY MALONE, EXECUTIVE DIRECTOR, FIA

RE: PUBLIC ASSISTANCE TO ADULTS DISABILITY CERTIFICATION FORM

PROGRAM AFFECTED: PUBLIC ASSISTANCE TO ADULTS (PAA)

ORIGINATING OFFICE: OFFICE OF PROGRAMS

SUMMARY: Customers applying for the Public Assistance to Adults (PAA) program are individuals living in protective living arrangements such as a Project (CARE) Home, Assisted Living or a Rehabilitative Residence. All PAA applicants must provide documentation of need. All PAA recipients get the $82.00 dollar personal needs allowance. Project Home and Assisted Living recipients receive assistance with their cost of care.

Currently, verification of need is recorded on the DHR/FIA 4352 Project Home Certificate, the DHR/FIA 500 Medical Report and the Representative Payee Agreement (SSA 132) form.

Reminder: The DHR/FIA 402B Medical Report and Physician Report of Eye Examination 701 are obsolete due to the introduction of the Medical Report DHR/FIA 500 form.

ACTION REQUIRED:

The Family Investment Administration created the Public Assistance to Adults Disability Certification form (DHR/FIA 4350) attached to streamline and simplify the process. This form **obsoletes** the DHR/FIA 4352. FIA will no longer use the SSA 132 form. Effective immediately, applicants applying for the Public Assistance to Adults program must use the DHR/FIA 4350 form and insure the form is completed by the appropriate person. Authorized Representatives must complete the Representative Payee Agreement

(Section I) regardless of the placement. Section II must be completed when the applicant is placed in a Rehabilitative Residence. When the applicant's impairment is based on medical or visual limitations the attending physician must complete Section III or Section IV.

INQUIRIES: Please direct PAA policy questions to Stephanie Hawkins at (410) 767-8121 or shawkins@dhr.state.md.us.

cc: DHR Executive Staff
FIA Management Staff
Constituent Services
DHR Help Desk

STATE OF MARYLAND
DEPARTMENT OF HUMAN RESOURCES
FAMILY INVESTMENT ADMINISTRATION

PUBLIC ASSISTANCE TO ADULTS DISABILITY CERTIFICATION FORM

SECTION I REPRESENTATIVE PAYEE'S AGREEMENT

In becoming a Representative Payee for _____ _____
(Name of Customer) (Customer ID)

I understand and agree to the following:

1. To use the assistance payment to obtain shelter, food, clothing, etc. for the customer.

2. To provide some accounting so that the local department can know how the money was used.

3. To the best of my ability, assist the customer in meeting daily needs; help with ongoing problems and to maintain a close contact with the customer.

4. To report to the local department any change in the financial circumstances of the customer of which I am aware; or any change in my relationship to the customer.

_____ _____
Representative Payee Date

_____ _____
LDSS Case Manager's Signature Date

SECTION II REHABILITATIVE RESIDENCE CERTIFICATION

(Rehabilitative Residence Completes)

The above named client has been approved for service and will be placed in Rehabilitative Residence housing. A public assistance application for the personal needs allowance will be submitted.

Facility: _____

Address: _____

Telephone No: _____

Service Eligibility has been established for: _____

Level of Care: _____

Planned Placement Date: _____

Mail Check to: _____

Address: _____

_____

SECTION III MEDICAL REPORT

The information provided on this form may be used to determine eligibility for federal and state programs using Social Security disability criteria.

Please Print or Type

PATIENT INFORMATION:

Name of Patient: _____ Date of Birth: _____

Physician's Name: _____

Address: _____

Specialty: _____

Phone: _____

Dates of Examination: First Visit: _____ Last Visit: _____

Presenting Symptoms:

_____

_____

_____

_____

Diagnosis: _____ Onset Date: _____

Diagnosis: _____ Onset Date: _____

Hearing Limitations ☐ Yes ☐ No ☐ Minimal ☐ Moderate ☐ Extreme ☐ Severe

Speaking Limitations ☐ Yes ☐ No ☐ Minimal ☐ Moderate ☐ Extreme ☐ Severe

MENTAL HEALTH

Does the patient suffer from mental illness? ☐ Yes ☐ No

_____

_____

_____

_____

_____

To the best of your knowledge does the patient exhibit any violent behaviors? ☐ Yes ☐ No

If yes, list below

_____

_____

_____

SECTION IV VISUAL LIMITATIONS

Visual Field: OD _____ OS _____ VA _____

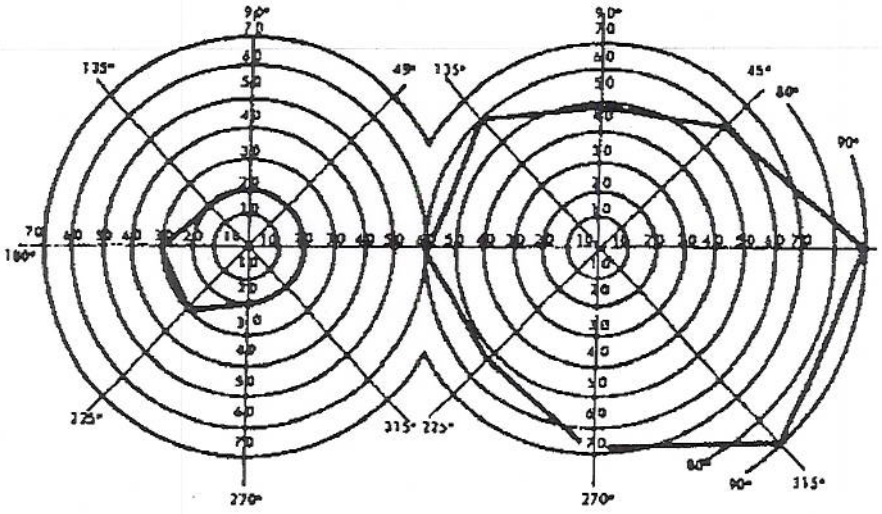
(After corrections): OD_____ OS _____ VA _____

PROGNOSIS AND RECOMMENDATIONS

Patient's vision impairment LEVEL **(PLEASE INDICATE BELOW)**

Stable _____ Deteriorating _____ Capable of Improvement_____ Uncertain_____

Other recommendations (e.g., special eye consultation, special medical examination, low-vision aide, mobility training, prostheses etc.; explain):



LEFT EYE (O.S.) RIGHT EYE (O.D.)

Additional Comments:

_____

_____

_____

_____

Signature: _____ Print Name: _____

Title: _____ Telephone: _____

License or Federal ID#:_____

MA Provider#: _____ Date: _____